United States Senate

COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION

WASHINGTON, DC 20510–6125

WEB SITE: http://commerce.senate.gov

November 2, 2009

H. Edward Hanway
Chairman and Chief Executive Officer
CIGNA Corporate Headquarters
Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192

Dear Mr. Hanway:

In the course of investigating how the health insurance industry spends consumers' premium dollars, the Senate Commerce Committee has found serious inconsistencies in the way CIGNA and its subsidiaries provide business information to the public and to their regulators. I am writing to request that you immediately provide information clarifying the amount of premiums you receive and the claims you pay for your group health insurance products.

Health insurance premiums have increased by more than twice the rate of inflation over the last decade. Consumers are seeing their health care premiums skyrocket, and many are concerned that fewer premium dollars are actually being spent on their medical care. The business side of health insurance refers to the percentage of premium dollars actually used to provide medical services as a "medical loss" on insurers' balance sheets, because paying medical claims reduces insurers' profit margins. This seems to run counter to the very purpose of health insurance. With nearly half a trillion dollars in premium subsidies proposed to be paid to private health insurance companies by taxpayers as a part of health care reform, it is critical that consumers have a guarantee that the overwhelming majority of subsidy dollars are going toward actual medical care.

I believe insurers have an obligation to use consumers' premium dollars in a way that maximizes the benefit to their policyholders. I also believe that consumers have the right to know what insurance companies are doing with their money. The medical loss ratio, the percentage of every dollar paid to an insurer in premiums that it uses to deliver health care, is a very basic measure of the value a consumer is getting from his or her health insurance. Just as a car buyer might use gas mileage to choose one car model over another, medical loss ratios are a tool that can help consumers compare various health insurance options. For this reason, I proposed setting an appropriate minimum medical loss ratio for insurers during the Senate Finance Committee's markup of the health reform bill, and intend to raise the issue again when health care reform is debated on the Senate floor.

To learn more about medical loss ratios in the commercial health insurance market, on August 21, 2009, I wrote to CIGNA and fourteen other large health insurance companies

requesting information about their medical loss ratios broken down by state and by the individual, small, and large group market segments. Collectively, these fifteen companies control more than half of the entire fully-insured marketplace, and represent a driving force in market behavior and price setting. The purpose of this request was to compile medical loss information in a way that would be useful for consumers shopping for individual health insurance policies or for business owners shopping for group policies for themselves and their employees.

In reviewing the responses CIGNA and other companies have made to my August 21 letter, I have been surprised to learn that insurance companies consider segment-specific medical loss ratio information "proprietary" and "business sensitive" and deliberately withhold it from the public. Instead of disclosing medical loss ratios to help consumers and small business owners make informed health care choices, health insurance companies have hidden them behind a wall of corporate secrecy.

Because CIGNA and other large, for-profit insurers have been reluctant to share their medical loss information with the Committee on a voluntary basis, the Committee staff has been analyzing premium and claims data these companies have already filed with the National Association of Insurance Commissioners (NAIC). As described in more detail below, the analysis shows that in the individual and small group segments, insurers spend a significantly smaller portion of each premium dollar on patient care than they do in their large group business. It also shows that the large for-profit health insurers appear to be squeezing out more profits for Wall Street investors by spending a lower percentage of premium dollars on patient care than other insurers.

In the course of this investigation, the Committee has also found serious inconsistencies in the way CIGNA and its subsidiaries provide business information to the public and to their regulators. Specifically, CIGNA appears to have submitted state insurance regulatory filings that do not accurately describe your business activities in the small and large group business segments. This failure to submit accurate medical loss ratio information to state insurance agencies not only appears to violate the law; it also undermines the efforts of policymakers, consumer advocates, and regulators to determine whether consumers are getting a fair value for their health care premium dollars.

In order to correct this problem, I request that you immediately submit accurate financial information both to this Committee and to state authorities.

A. Background on the Medical Loss Ratio

One of the basic financial measures used in the health care industry is the percentage of health insurance premiums that insurers use to provide health care to their customers. This

percentage is commonly known as the "medical loss ratio."[1] For example, if an insurer uses 75 cents out of every premium dollar to pay its customers' medical claims, the company has a medical loss ratio of 75%. A medical loss ratio of 75% indicates that the insurer is using the remaining 25 cents of each premium dollar to pay expenses that do not directly benefit policyholders, such as salaries, administrative costs, advertising, agent commissions, and profits.

Regulators, consumers, policy makers, investors and even insurance companies themselves use medical loss ratios to assess how insurers manage their assets and provide health care services to their customers.[2] But these groups analyze medical loss ratios for different purposes. Regulators, consumers and policymakers study them to determine if insurers are spending an appropriate portion of premium dollars on medical services. Investors and the insurance companies they own use medical loss ratios determine the companies' profitability.

Regulators and Consumers

State insurance regulators use medical loss ratio information to make sure that insurers operating in their states are financially solvent and that consumers are getting sufficient value for their health insurance premiums.[3] According to a recent review of state insurance laws by America's Health Insurance Plans (AHIP), 32 states currently require insurance companies to report medical loss ratios in either their individual or group major medical insurance markets.[4]

Many of these states have taken the further step of implementing "minimum medical loss ratios" to limit the portion of premium dollars insurers can use for administrative expenses and profits. In a recent study on the impact of minimum medical loss ratios in the small group market in Texas, the Center for Public Policy Priorities made the following observation:

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[1] Some insurers use different terms to describe this ratio, such as "medical cost ratio," "benefits expense ratio" or "medical care ratio." According to one health care expert, "traditionally, actuaries had called this fraction the *medical loss ratio* (M.L.R.), because it represents what insurers "lose," so to speak, to doctors, hospitals and other providers of health care. Because that terminology comes across as indelicate, however, the preferred term now is the mellower *health benefit ratio* (H.B.R.)" Uwe E. Reinhardt, *How Much Money Do Insurance Companies Make? A Primer.* New York Times Economix Blog (Sept. 25, 2009) (online at http://economix.blogs.nytimes.com/2009/09/25/how-much-money-do-insurance-companies-make-a-primer).

[2] American Academy of Actuaries Loss Ratio Working Group, *Loss Ratios and Health Coverage* (November 1998) (online at http://www.actuary.org/pdf/health/lossratios.pdf).

[3] *Id.*

[4] America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Sept. 8, 2009). This document was provided to the Committee by at least 3 different insurance companies. *See also* Families USA Health Policy Memo, *Medical Loss Ratios: Evidence from the States* (June 2008) (online at http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf).

> Some states set minimum medical loss ratios by law to prevent insurance companies from charging excessive rates and retaining large margins for profit and other non-medical expenses. Establishing a minimum standard for the proportion of premiums spent on medical care provides consumers with an assurance that the majority of their premium dollars are used to help them finance their health care – the reason people buy health insurance.[5]

Thirteen states require insurance companies to maintain minimum medical loss ratios in their individual markets.[6] These minimum ratios range from a low of 50% in Pennsylvania to a high of 80% in neighboring New Jersey.[7] Thirteen states require companies to maintain minimum medical loss ratios in their small group markets (generally, businesses with fewer than 50 employees), with minimum ratios ranging from 60% to 82%.[8] Five states require companies to maintain minimum medical loss ratios in their large group markets.[9] These minimums range from 65% to 85%.

At least five of these state minimum ratio laws require insurers to return premium payments to consumers if their medical benefits payments fall below the state-mandated minimum percentages.[10] In response to the Committee's inquiry to the 15 largest health insurers whether they had issued rebates in compliance with these refund laws over the past 5 years, 4 insurers reported they returned amounts totaling $73.2 million. The fact that the insurance companies do, on occasion, dip below required minimum loss ratios suggests that minimum loss ratio standards keep the percentage of premium dollars spent on healthcare higher than it would be without such a requirement.

From the perspective of an individual consumer or business shopping for insurance coverage, medical loss ratios provide useful information about the relative value of health plans with similar benefit structures. Just as a car buyer might use gas mileage to choose one car model over another, "medical loss ratios are one additional tool consumers can use to compare similar products and better understand what they get for their premium dollar."[11]

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[5] Center for Public Policy Priorities, *How to Improve the Health Insurance Market Using Medical Loss Ratios* (No. 09-400) (May 15, 2009) (online at http://www.cppp.org/files/3/400_MLR_report.pdf).

[6] America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Sept. 8, 2009).

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Id.* According to AHIP, these five states are Maine, New Jersey, New York, North Carolina, and South Carolina.

[11] Center for Public Policy Priorities, *How to Improve the Health Insurance Market Using Medical Loss Ratios* (No. 09-400) (May 15, 2009) (online at http://www.cppp.org/files/3/400_MLR_report.pdf).

Investors

The health care consulting group, PricewaterhouseCoopers, reports that: "MLRs [medical loss ratios] are closely watched barometers of financial performance for investors."[12] But unlike regulators and consumers, who are looking for medical loss ratios high enough to demonstrate that a health insurance product is a good value, potential investors are looking for low ratios. Low and declining medical loss ratios signal to the market that an insurer is successfully containing its medical costs and is likely to operate profitably in the future.[13] A guide to investing in health companies on the Investopedia website counsels investors that the medical loss ratio "is the key ratio investors consider. It basically tells the investor how much the medical expenses are as a percentage of premiums…Investors like to see a low medical cost ratio."[14]

On June 24, 2009, a former CIGNA executive, Wendell Potter, testified before the Commerce Committee that CIGNA and other for-profit insurance companies are under intense pressure from Wall Street to contain their medical costs. At the end of every quarter, Mr. Potter testified, insurance executives provide their financial results on investor conference calls.

> On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical loss ratio…To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen one insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9% to 79.4% a year later.[15]

According to Mr. Potter, for-profit insurers employ several different strategies to exert continuous downward pressure on their medical loss ratios. In the individual market, for-profit

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[12] Pricewaterhouse Coopers' Health Research Institute, *Beyond the Sound Bite: Review of Presidential Candidates' Proposals for Health Reform*, 38 (Nov. 2007).

[13] American Academy of Actuaries Loss Ratio Working Group, *Loss Ratios and Health Coverage*, 7 (November 1998). "From the investor's perspective, the lowest loss ratio is best because it means more risk margin to provide for profit and for potential adverse experience fluctuations."

[14] Investopedia, *Investing in Health Insurance Companies,* (online at http://www.investopedia.com/articles/stocks/09/investing-in-health-insurance.asp) (accessed Oct. 26, 2009).

[15] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Wendell Potter.

insurers engage in post-underwriting rescission, where insurers "look carefully to see if a sick policyholder may have omitted a minor illness, or a pre-existing condition when applying for coverage, and then they use that as a justification to cancel the policy."[16] In the small group market, Mr. Potter described how insurers "purge" small businesses with high health care expenses by increasing premiums to unsustainable levels.[17]

The Health Insurance Industry's Conflicting Loss Ratio Numbers

For-profit health insurance companies such as CIGNA struggle to please two different audiences with sharply divergent interests. On the one hand, they try to demonstrate to regulators and consumers that they use a high percentage of premium dollars to provide health care. At the same time, as Mr. Potter explained to the Committee, insurers know that Wall Street will reward them for containing their benefit expenses and lowering their medical loss ratios.

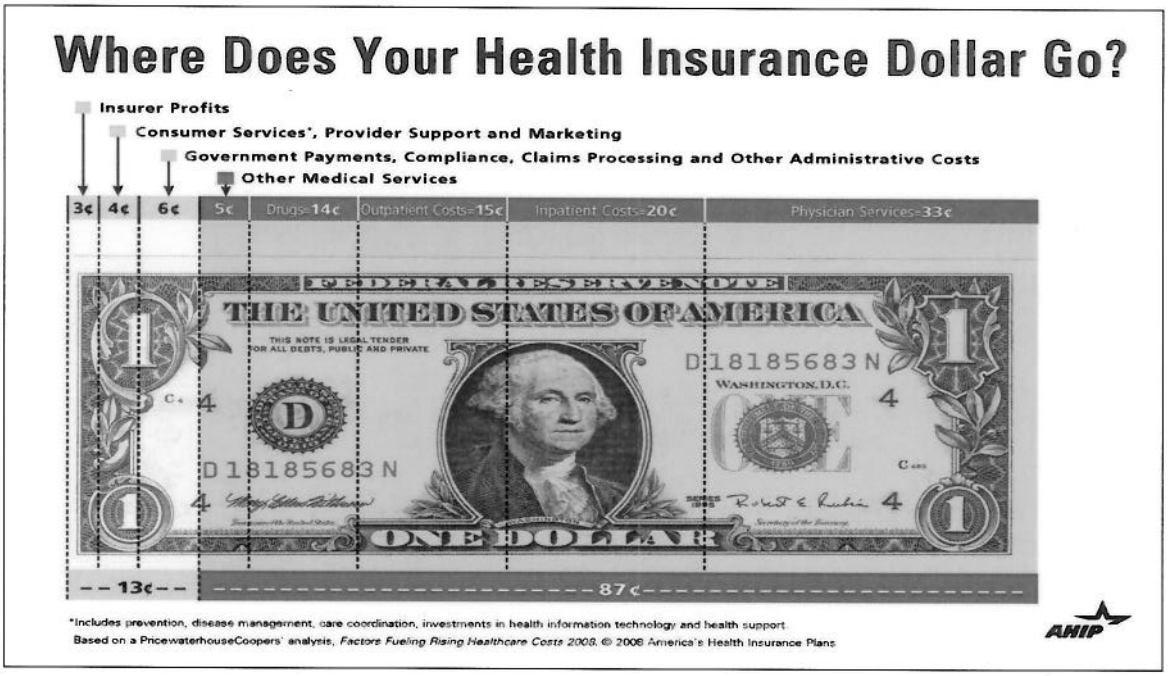

FIGURE I – AHIP Presentation of the Expenditure of a Premium Dollar

During the health care reform debate this year, the health insurance industry has provided one set of premium-benefit numbers to the public and to Congress, and presented a different one

[16] *Id. See also,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Termination of Individual Health Policies by Insurance Companies,* 111th Congress (June 16, 2009).

[17] *Id. See also,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on the High Cost of Small Business Health Insurance: Limited Options, Limited Coverage*, 111th Congress (Oct. 20, 2009).

to their investors. In an expensive public relations effort, the health insurance industry's association, America's Health Insurance Plans (AHIP), has repeatedly cited a report it commissioned from PricewaterhouseCoopers that purports to show that in 2008, 87% of health insurance premiums were spent on health care costs, while 13% were spent on administrative costs.[18] As part of this public relations effort, AHIP has repeatedly published graphics showing that the industry spends 87% of every premium dollar on health care (see Figure I above).

However, the industry's representation that insurance companies spend 87 cents of every premium dollar on medical care is contradicted by its own financial reporting. A review of the Securities and Exchange Commission (SEC) filings of the six largest, publicly-traded health insurers, including CIGNA, shows that not a single one of those companies spent 87 cents of every dollar on medical care for their customers in 2008 (see Table I below).

Company	2008 Medical Loss Ratio
Aetna	81.5%
CIGNA	84.8%
Coventry	84%
Humana	84.5%
UnitedHealth	82%
WellPoint	83.6%

TABLE I – 2008 Medical Loss Ratios Presented by For-Profit Insurers to Their Investors

Given that CIGNA and the five other companies listed in Table I above collected more than $70 billion in premiums from their commercial insurance customers in 2008, the difference between AHIP's 87% figure and the companies' actual figures equates to billions of dollars that the health insurance industry claims to spend providing health care, but actually uses to bolster its profits or pay other non-benefit expenses.

Further evidence that AHIP's 87% premium-benefit figure misrepresents the true ratios within the health insurance industry is an analysis published by PricewaterhouseCoopers Health Research Institute in 2007. The analysis shows that, over the past 15 years, the medical-loss ratios of publicly traded health insurance companies have dropped from the 90-95% range to the low 80s.[19] According to this PricewaterhouseCoopers report, it has been almost a decade since the industry-wide medical loss ratio was higher than 85% (see Figure II).

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[18] PricewaterhouseCoopers, *Factors Fueling Rising Healthcare Costs 2008*, Prepared for AHIP (Dec. 2008).

[19] PricewaterhouseCoopers' Health Research Institute, *Beyond the Sound Bite: Review of Presidential Candidates' Proposals for Health Reform*, 39 (Nov. 2007).

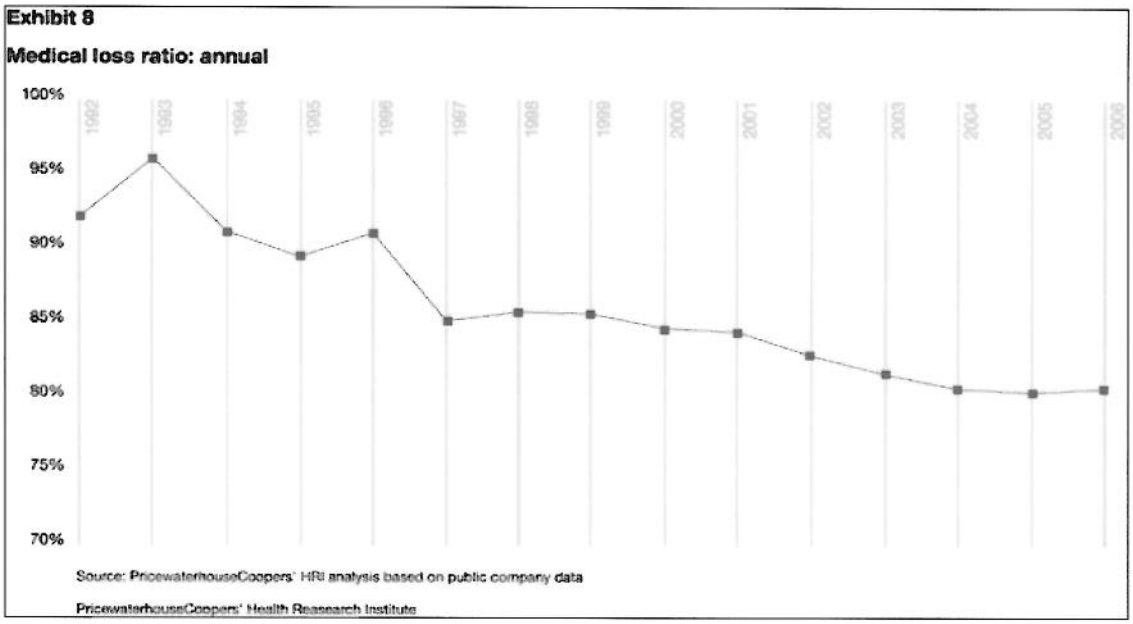

FIGURE II – PricewaterhouseCoopers Analysis of Medical Loss Ratio

In his June 24 testimony before the Commerce Committee, Mr. Potter cited this PricewaterhouseCoopers analysis as evidence of "just how successful the insurers' expense management and purging actions have been over the last decade in meeting Wall Street's expectations." [20] A reduction of a few points in the industry's medical loss ratio "translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients."[21]

Medical Loss Ratios as a Tool for Consumers

Although medical loss ratios are a widely used indicator of performance in the health insurance industry, they do not provide consumers with information about the quality or effectiveness of the care they will receive through a particular health insurance product. In fact, health insurers have been quick to point out to Committee staff the shortcomings of the medical loss ratio, repeatedly directing the Committee's attention to an academic article in which the author calls the medical loss ratio an "accounting monstrosity."[22]

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[20] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Wendell Potter.

[21] *Id.*

[22] James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, Health Affairs, Vol. 16, No. 4, 186 (July/Aug. 1997) (online at http://content.healthaffairs.org/cgi/reprint/16/4/176).